

# IDAHO STATE BOARD OF MEDICINE

P.O. Box 83720 · Boise, ID 83720-0058 · (208) 327-7000

Express Mail: 1755 Westgate Drive, #140 · Boise, ID 83704

## APPLICATION - POLYSOMNOGRAPHY RELATED RESPIRATORY CARE PERMIT

### FOR USE OF THE BOARD

1. Prof. Education	2. Training	3. BRPT	4. Recommendation	Received	PSG Trainee #	PSG Permit #
5. Recommendation	6. Verification	7. Supervisor	CPR	Fees	Date	Date

**Before completing, please see instructions.**

I hereby apply to provide polysomnography related respiratory care as a:

- ☐ PSG Technologist  
☐ PSG Technician  
☐ PSG Trainee

**Make check(s) payable to: IDAHO STATE BOARD OF MEDICINE**

First Name		Middle Name		Last Name			
Current Address (Street, City, State, Zip)						Telephone	
New Address (Street, City, State, Zip) and Effective Date						Social Security No.	
Place of Birth (City and State)						Date of Birth (Month, Date, Year)	
Height (Ft., In.)	Weight	Hair	Eyes	Complexion	Scars, Marks	Sex: Male Female	
NAME AND LOCATION OF SCHOOLS			FROM (Month, Day, Year)		TO (Month, Day, Year)		
High School							
College/University							
Polysomnography Program							
Postgraduate Study							

**BRPT Registry Number:** \_\_\_\_\_

I HAVE APPLIED FOR LICENSURE, REGISTRATION OR PERMIT IN THE FOLLOWING STATES OR COUNTRIES	Year	GRANTED CURRENT				NUMBER	APPLICATION BASED UPON	
		Yes	No	Yes	No		Endorse.	Exam.

In chronological order account for all periods of time beginning with the month applicant last received training/education up to the present time, leaving no gap in time of more than one month (employed, unemployed, studying for the exam, military service, extended vacation, etc.) Attach additional pages if necessary.

FROM (Month, Day, Year)	TO (Month, Day, Year)	NAME OF INSTITUTION OR PLACE OF PRACTICE AND LOCATION	EMPLOYER

#### NOTE

Attach a finished photograph of your head and shoulders only. Photo must have been taken within the last year and be 3"x4" in size. **Sign the photo in ink across the lower portion of the front side.**

**Proof photos, negatives, copies, and instant photos are not acceptable.**

#### CERTIFICATION

IF THE ANSWERS TO ANY OF THE FOLLOWING QUESTIONS IS YES, PLEASE PROVIDE DETAILS ON A SEPARATE, ATTACHED SHEET.

Y N

- ☐ ☐ Have you ever failed a registration exam?
- ☐ ☐ Have you ever been refused a professional license/registration/permit?
- ☐ ☐ Have you ever been charged with or convicted of a felony or misdemeanor other than minor traffic violations?
- ☐ ☐ Have you ever been investigated by any licensing board, agency or professional association in connection with competency, practice act violations, unprofessional conduct or unethical conduct?
- ☐ ☐ Have you ever been subject to informal or formal proceedings by any licensing board, agency or professional association to revoke, suspend, restrict or limit a professional license/registration/permit?
- ☐ ☐ Do you currently have or have you had any serious physical or mental condition in the past five years which in any way impairs or limits your ability to practice polysomnography related respiratory care with reasonable skill and safety?
- ☐ ☐ Do you now or have you ever had employment terminated or restricted, or limitations imposed on such employment or resigned from employment to avoid formal action?
- ☐ ☐ Do you currently have or have you had problems with the use of alcohol, stimulants, habit forming and/or illegal drugs in the past five years which in any way impairs or limits your ability to practice polysomnography related respiratory care with reasonable skill and safety?

I, \_\_\_\_\_, being first fully sworn, depose and say that I am the person herein described and identified; that the answers to the accompanying questions and statements made in this application are true and correct; that I am the lawful holder of the degrees/credentials listed, and that such degrees/certificates were procured in the regular course of instruction and examination without fraud or misrepresentation.

I hereby authorize all hospitals, institutions or organizations, my references, personal associates, business associations (past and present) and all government agencies and instrumentalities to release to this licensing Board and information, files or records requested by this Board in connection with the processing of this application. I further authorize this Board to release to the organizations, individuals and groups listed above any information which is material to my application or pertinent to my practicing polysomnography related respiratory care.

I have carefully read the questions in the accompanying application and have answered them completely, without reservation of any kind, and declare under penalty of perjury that my answers and all statements made by me herein are true and correct. Should I furnish any false information with this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my permit to practice polysomnography related respiratory care in the State of Idaho.

I further declare that the photo of myself attached hereto was taken on or about \_\_\_\_\_, 20\_\_\_\_, my age being \_\_\_\_\_.

State \_\_\_\_\_ County of \_\_\_\_\_

Subscribed and Sworn to before me this \_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

(SEAL) Notary Signature \_\_\_\_\_

My commission expires \_\_\_\_\_

Signature of applicant \_\_\_\_\_

## CERTIFICATE OF PROFESSIONAL EDUCATION

Please have the following completed by the appropriate educational institution and return directly to the Idaho State Board of Medicine, PO Box 83720, Boise, ID 83720-0058; Express Mail: 1755 Westgate Dr. #140, Boise, ID 83704.

Full Name of Applicant:	
Address:	
Social Security Number:	Date of Birth:
Associate Degree:	Date of Degree:
Certificate of Completion:	Date of Certification:

Dates of Attendance:	From (Date)	To (Date)
First Year		
Second Year		
Third Year		
Fourth Year		

I hereby certify that the above named applicant completed training as indicated above and received a certificate of completion.

\_\_\_\_\_  
Please type or print name of Director

\_\_\_\_\_  
Signature of Director

\_\_\_\_\_  
Name of School or Facility

\_\_\_\_\_  
If changed, present name

\_\_\_\_\_  
City State Zip

\_\_\_\_\_  
Date of This Certification

(SEAL)

\_\_\_\_\_  
Applicant's signature

## VERIFICATION OF TRAINING

I am applying for a permit to practice **polysomnography related respiratory care** in the State of Idaho. Please complete and return form directly to the Idaho State Board of Medicine, P.O. Box 83720, Boise, ID 83720-0058; Express Mail: 1755 Westgate Dr., Ste. 140, Boise, ID 83704. (This form can be duplicated.)

Applicant's Name: \_\_\_\_\_

Address: \_\_\_\_\_

### EMPLOYMENT

Employer (facility): \_\_\_\_\_

Address: \_\_\_\_\_

Supervisor (Full Name)

Telephone

License No.

Must be a polysomnography technologist/technician with an active Idaho permit, permanent licensed respiratory care practitioner, and/or physician and must complete the Affidavit of Supervisor.

### TRAINING

Date: \_\_\_\_\_ TO \_\_\_\_\_ No. of Hours \_\_\_\_\_

Duties during the above dates: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Proficiency in above duties (circle one): Poor Fair Good Excellent

### AFFIDAVIT OF SUPERVISOR

I have carefully read the above questions regarding training and have answered them completely, without reservation of any kind, and declare under penalty of perjury that my answers and all statements made by me herein are true and correct.

\_\_\_\_\_  
Signature of Supervisor

State \_\_\_\_\_ County of \_\_\_\_\_

Subscribed and sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

Notary signature \_\_\_\_\_

My commission expires \_\_\_\_\_

## CERTIFICATE OF RECOMMENDATION

I am applying for licensure to practice **polysomnography related respiratory care** in the State of Idaho. Please complete and return for directly to the Idaho State Board of Medicine, P.O. Box 83720, Boise, Idaho 83720-0058; Express Mail: 1755 Westgate Drive, #140, Boise, Idaho 83704. (Note: **Two** certificates of recommendation are required. Please duplicate this form. Recommendations should be from persons who have known the applicant professionally for at least **one year**.)

Applicant's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Recommending Person's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Profession: \_\_\_\_\_

Do you request that this information be confidential? ☐ Yes ☐ No

TO: Idaho State Board of Medicine:

I have known \_\_\_\_\_ for \_\_\_\_\_ years,  
from \_\_\_\_\_ to \_\_\_\_\_ while he/she was studying  
or practicing polysomnography. To the best of my knowledge he/she  
is of good moral and professional character and ethics.

Additional Comments:

\_\_\_\_\_  
Signature

## VERIFICATION OF REGISTRATION/LICENSURE/PERMIT

Please complete and return form directly to the Idaho State Board of Medicine, P.O. Box 83720, Boise, ID 83720-0058; Express Mail: 1755 Westgate Drive, #140, Boise, Idaho 83704. (If additional forms are needed, this form may be duplicated)

I am applying for a permit to practice polysomnography related respiratory care in the state of Idaho. The Idaho State Board of Medicine requires verification of registration/licensure/permit from each state wherein I hold or have held registration/licensure/permit. This is your authority to release any information in your files favorable or otherwise, directly to the Idaho State Board of Medicine, at the address indicated above.

Applicant's Name: \_\_\_\_\_

Applicant's Address: \_\_\_\_\_

My Registration/License/Permit No. is: \_\_\_\_\_

Do you request that this information be confidential? \_\_\_\_ Yes \_\_\_\_ No

State of: \_\_\_\_\_ Registration/License/Permit No.: \_\_\_\_\_ Issue Date: \_\_\_\_\_

Name of Registrant/Licensee: \_\_\_\_\_

Issued by: \_\_\_\_\_ Endorsement/Reciprocity with: \_\_\_\_\_

\_\_\_\_\_  
Examination (BRPT)

Status: Current Yes \_\_\_\_ No \_\_\_\_ Expiration Date \_\_\_\_\_

Do you have any record of disciplinary or legal action that should be considered with this polysomnographer's application? Yes \_\_\_\_ No \_\_\_\_

Comments:

(Board Seal)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

\_\_\_\_\_  
State Board

***Verification - Not an Endorsement***